MEDICAL BOARD OF CALIFORNIA

Licensing Program

CERTIFICATE OF MEDICAL EDUCATION

Check one: ☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

NAME: **Last** **First** **Middle**

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Name of Medical School	
State/Province/Country	
Did the applicant complete an English Language program?	❑ Yes ❑ No

The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ *years* of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2). **The standard duration of the curriculum at this institution is _____ years.**

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology, and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventative Medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Spousal Partner Abuse Detection & Treatment*
Family Medicine**
Pain Management and End-of-Life-Care***

* **ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994**
** **ONLY applicable to medical students who graduated from medical school on or after June 30, 1999**
*** **ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000**

Date the applicant enrolled in medical school:	__ __/ __ __/ __ __ __ __
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:	__ __/ __ __/ __ __ __ __
Date the applicant withdrew from medical school (if applicable):	__ __/ __ __/ __ __ __ __

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

1. Did this applicant ever take a leave of absence from his/her medical education?	❑ Yes ❑ No
2. Was this applicant ever placed on probation?	❑ Yes ❑ No
3. Was this applicant ever disciplined or placed under investigation?	❑ Yes ❑ No
4. Were any negative reports regarding this applicant ever filed by instructors?	❑ Yes ❑ No
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	❑ Yes ❑ No

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINTED NAME OF SCHOOL OFFICIAL **TITLE OF SCHOOL OFFICIAL**

SIGNATURE OF SCHOOL OFFICIAL **DATE**

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MBC Use Only

Medical School Information ❑ ❑ ❑ ❑ ❑

Dates of Attendance ❑ ❑ ❑

Unusual Circumstances ❑ ❑ ❑ ❑ ❑

Signature & Seal ❑

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NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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